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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN OF	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU!		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
			445494	B. WIN	IG		03	/02/2012
		R OR SUPPLIER	UNTY , 8		7	REET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321		
(X4) ID PREFIX TAG		(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	An usuas Marco was requithes 483. PRIV The record meet does room Excers section released individual to the reside institution of the reside institut	conducted on Fe h 2, 2012. Life C not in substantial rements of 42 Ci irements for Lon urvey. The facilit 0(e), 483.75(I)(4) ACY/CONFIDEN esident has the redentiality of his ords. In all privacy inclucal treatment, wrinunications, persings of family and not require the fafor each resident made of personal and tual outside the fasident's right to be in its transferred to cility must keep ecility must keep ecility must keep and to the substantial record resident must keep ecility must keep and the substantial record resident must keep ecility must	deral Comparative survey bruary 28, 2012 through are Center of Rhea County compliance with the FR 483 and 488, Subpart B, g Term Care at the time of ty census was 83.) PERSONAL ITIALITY OF RECORDS ight to personal privacy and r her personal and clinical des accommodations, tten and telephone onal care, visits, and d resident groups, but this acility to provide a private t. paragraph (e)(3) of this hay approve or refuse the d clinical records to any		164	1) What corrective action will be accomplished for those residents found to have been affected by The deficient practice? LPN #2 received education on provent privacy to residents while administ Medication per gastrostomy tube be Staff Development Coordinator (R) 3/15/12 to Resident #9, and all other This education included the require ensure the room door is closed, the privacy curtain is completely purnous visitors are in the area unless other preferred by the resident when care provided. Wound Care Nurse and the Activities received education on providing Privacy to residents while providing Staff Development Coordinator (R) And 3/16/12 to Resident #1, and all This education included the requiremensure the room door is closed, the privacy curtain is completely pul no visitors are in the area unless other preferred by the resident when care is	ering y the N) on residents. ment to elled, and erwise is being es Director care by the 1) on 3/15/12 other residenent to led, and erwise	3/23/12 nts.
	the fo releas health contra	rm or storage me to is required by to care institution; later, act; or the residen	thods, except when ransfer to another aw, third party payment it.			provided.		3 23 12
ABORATORY D	IRECTO	R'S OR PROVIDER/SU	IPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	2/2	(X6) DATE

Any deficiency statement ending with an asterisk (2) benotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

rogram participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: TN7202

PRINTED: 03/14/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WNG 445494 03/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY LIFE CARE CENTER OF RHEA COUNTY DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 164 Continued From page 1 F 164 How will you identify other residents having the potential to be affected by the same deficient practice and This REQUIREMENT is not met as evidenced what corrective action will be taken? Based on observation and staff interview, the The Staff Development Coordinator (RN) facility failed to ensure privacy during the Educated facility associates from 3/15/12 administration of medication for one (1) 12 Through 3/22/12 on providing privacy to residents residents observed during the Medication Pass While providing care. This education (Resident #9), and failed to provide privacy during included the requirement to ensure the room door is closed, wound care for one (1) of 23 sampled residents the privacy curtain is completely pulled, and (Resident #1). no visitors are in the area unless otherwise preferred by the resident when care is being The findings include: provided. Associates educated include RN, LPN, C.N.A, Rehab, Administration, Medical Records, 1. An observation during the Medication Pass Maintenance, Social Services, Environmental conducted on 3/2/12 at 11:15 a.m. revealed Services, Activities, and Dietary departments. 3/23/12 Licensed Practical Nurse (LPN) #2 administered 25 of Hydralazine to Resident #9 through his gastrostomy tube. The resident's abdomen was What measures will be put into place exposed as the nurse checked the placement of or what systematic changes will you make the tube and administered the medication and to ensure that the deficient practices water flushes through the gastrostomy tube. will not recur? Prior to administering the medication, LPN #2 The Staff Development Coordinator (RN) Will complete weekly random verbal testing failed to close the door to the resident's room that Of facility associates of resident privacy, led into the hallway and failed to close the privacy And weekly observation on privacy given to curtain around the resident's bed. The resident's Residents during care for three consecutive wife and daughter were present in the room at the Months. After these 3 months the SDC will time of the medication pass as well as two (2) continue the random verbal testing of the facility other residents present in the hallway outside of

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the room.

During an interview with LPN #2 immediately after the observation, she confirmed the door was not

 Resident #1 was re-admitted to the facility on 10/31/11 with diagnoses of Diabetes Mellitus,

closed and the curtain was not pulled.

Event ID:5ZYY11

Facility ID: TN7202

for one year.

associates on resident privacy, and observation

on privacy given to resident during care monthly

If continuation sheet Page 2 of 34

3/23/0

STATEMEN AND PLAN			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	(X3) DATE S COMPLI	
			445494	B. WNG)	03	/02/2012
		R OR SUPPLIER TER OF RHEA CO	UNTY 2		STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321		
(X4) ID PREFIX TAG		(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 164	Durir on 3/ provi The post of the least of t	ase, Anxiety and atest Minimum D ssed the resident view for Mental Sent was cognitive and a destruction of the resident was to ropened the dounced to the resident sent was exposed from a gelevated during ant's reflection was the sink which controlled the resident. As corway, the Treatment of the resident after being question of the resident.	C Obstructive Pulmonary Chronic Renal Disease. ata Set (MDS) dated 2/2/12 as scoring 13 on the Brief tatus (BIMS) indicating the	F 1	4) How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? The Staff Development Coordinate The findings of the weekly and moverbal testing of facility associates privacy, and weekly and monthly oprivacy given to residents during care Performance Improvement Commit monthly for three consecutive mont monthly for one year. The Perform Improvement Committee consisting Executive Director, Medical Director Office Manager, Staff Development Wound Care Nurse, Director of Med Director of Environmental Service, Of Maintenance, Director of Social Director of Human Resources, Director of Human Resources, Director of Food and Nutrition Servi Director of Admissions/Marketing with findings and make recommendat develop plans of action if any areas a be non-compliant.	r will present nthly random of resident beervation on re to the tee hs, and ance of the or, Business Coordinator, ical Records, Director Services, stor of Rehab cotor of Nursing ces, and ill review ons and	3/23/12
F 253 SS=D	the nuclosed medic 483.1 MAIN	at approximately rses should have the door before ation and during to h)(2) HOUSEKE (ENANCE SERV) cility must provide thance services n	the wound care. EEPING &	F 253	What corrective action will accomplished for those resi found to have been affected. The deficient practice?	dents	

PRINTED: 03/14/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0301 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG 445494 03/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY LIFE CARE CENTER OF RHEA COUNTY 1 DAYTON, TN 37321 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 253 Continued From page 3 F 253 The Maintenance Assistant replaced The sink and faucet in room numbers One (1) and two (2) on 3/12/12. The water This REQUIREMENT is not met as evidenced 3/23/12 Pressure is adequate in these rooms. Based on observation and staff interview, the The Maintenance Assistant and Director facility failed to ensure bathroom faucets were Of Maintenance filed and repaired the repaired, nail heads were nailed down, light Nails sticking out of the tile, behind The toilet, and sticking up through the fixtures were intact, holes in walls were repaired. Floor around the toilet in the bathrooms ceiling tiles and linoleum were free from stain and In rooms three (3) and four (4) on 3/19/12. walls were free from cracked and peeling paint for two (2) of two (2) resident units and one (1) of The Maintenance Assistant and Director thee (3) common baths. Of Maintenance replaced the light fixture(s) In room five (5) and six (6) on 3/19/12. The findings include: The Maintenance Assistant replaced the During initial tour on 2/28/2012 between the hours Cover for the cords that are attached to the Wall and connected to the outlet, next to the of 12:30 p.m. and 1:50 p.m. observations were as 3/23/12 3/23/12 3/23/12 Sink in the Rehabilitation common shower follows: Room on 3/21/12. 1. The water pressure from the bathroom sink for The Maintenance Assistant repaired the three room one (1) and two (2), was very low. (3) holes present in the wall below the tissue Holder in the bathroom in Room 20 using The bathroom for room three (3) and four (4) Spackling on 3/6/12.

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floor around the toilet.

six (6), had multiple cracks.

wall below the tissue holder

had five (5) nails sticking out of the tile, behind

the toilet and one (1) nail sticking up through the

3. The bathroom light fixture for room five (5) and

4. The Rehabilitation common shower had a rusty cover for the cords that were attached to the wall and connected to the outlet, next to the sink.

5. Unit "D" Hall- In the bathroom in Room 20, approximately three (3) holes were present in the

Event ID: 5ZYY11

Facility ID: TN7202

The Maintenance Assistant repaired the five

(5) holes around the toilet tissue holder in the Bathroom for room 22 and 23 using spackling On 3/9/12. This associate also replaced the

Linoleum in this bathroom on 3/23/12.

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/14/201: M APPROVED O: 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		445494	B. WNG_		03/	02/2012
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE CENTER OF RHEA CO	PUNTY		7824 RHEA COUNTY HWY DAYTON, TN 37321		
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F 253	This REQUIREMENT	is not met as evidenced	F 25	Walls on 3/6/12 for holes, and 20 rema bathrooms were corrected with spackling Bathrooms corrected were 24/25, 26/2 32/33, 35/36, 40/41, 42/43, 44/45, 46/47	ining ng. 7, 28/29,	
	facility failed to ensur repaired, nail heads v	n and staff interview, the e bathroom faucets were vere nailed down, light oles in walls were repaired,		48/49. Three other rooms were Identified to need linoleum, rooms 31, 3 The Director of Maintenance review the Common shower areas (2) for peeling of	88, and 40. e remaining or cracking	3/23/12
	walls were free from o	um were free from stain and cracked and peeling paint esident units and one (1) of		Paint, and dark ceiling tiles on 3/13/12. Issues were found.	No further	3/23/12
	thee (3) common bath			The Director of Environmental Services The remaining resident bathroom linole Dark brown stains on 3/16/12. Four other	um for er bathrooms	i -
	The findings include: During initial tour on 2	/28/2012 between the hours		Were noted to have dark brown stains. I Maintenance Assistant replaced the lino In these four bathrooms on 3/23/12.	The	ו a
		p.m. observations were as		The Director of Maintenance reviewed Remaining resident bathrooms for		3/23/12 .
	1. The water pressure room one (1) and two	from the bathroom sink for (2), was very low.		Nails sticking out of the tile, behind The toilet, and sticking up through the Floor around the toilet in the bathrooms		
	had five (5) nails sticki	om three (3) and four (4) ng out of the tile, behind ail sticking up through the		On 3/16/12. No additional nails were for But some holes were repaired in walls w Spackle.	ind, ith	3/23/12
	floor around the toilet.			The Director of Maintenance reviewed the light fixtures in the remaining residen rooms on 3/15/12. These light fixtures do	t	
	six (6), had multiple cr	ixture for room five (5) and acks.		not have cracks.		3/23/15
		ommon shower had a rusty were attached to the wall utlet, next to the sink.		The Director of Maintenance reviewed the Cover for the cords that are attached to the Wall and connected to the outlet, next to the Sink in the remaining shower rooms On 3/16/12. No covers are rusty at this time.	e he	3/23/12
	 Unit "D" Hall- In the approximately three (3) wall below the tissue h 	holes were present in the		*		

PRINTED: 03/14/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 445494 03/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY LIFE CARE CENTER OF RHEA COUNTY DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 4 F 253 6. Unit "D" Hall- In the bathroom for room 22 and 3) What measures will be put into place 23, there were five (5) approximately 3-5 inch or what systematic changes will you make holes around the toilet tissue holder and the to ensure that the deficient practices linoleum had dark brown stains. will not recur? 8. Unit "D" Hall common shower-The upper. The Director of Maintenance will conduct 10-inch area around the ceiling on the wall had A weekly random water pressure and protruding Nail review of resident bathrooms, and make peeling and cracking paint. Approximately four (4) correction as necessary. This review will be ceiling tiles around a heating unit were discolored completed for three months, and then once with dark, black stains. per month for one year. This will be documented in a log as part of the preventive 9. Unit "D" Hall- Room 39 bathroom had four (4), maintenance program. 2 to 3 inch holes around the toilet tissue holder. 3/23/12 The liholeum was stained with dark, brownish The Director of Maintenance will conduct stains around the toilet. A monthly review of facility light fixtures, Outlet covers, flooring, and walls for any Needed repairs, and add to the Preventive 10. Unit "D" Hall-Room 22 had a foot long hole in Maintenance program. This will be the wall, next to the room's heating/air documented in a log as part of the preventive conditioning unit. maintenance program. 3/23/12 11. Uhit "D" hall- Room 24 had a 5 inch hole on the interior wall, next to bed "A." During an interview with the facility's maintenance Manager and Director, on 2/29/2012 at 11 a.m., he stated the bathroom faucet in Room 1 and 2 needed to be completely changed out. They both confirmed all of the aforementioned findings and stated "Repairs would begin right away." F 280

SS=D

483.20(d)(3), 483.10(k)(2) RIGHT TO

changes in care and treatment.

PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapabitated under the laws of the State, to participate in planning care and treatment or F 280

ATEME	NT OF DEF OF CORR	CIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JUTIPLE CONSTRUCTION	(X3) DATE COMPI	
			445494	B. WIN			•
ME OF	PROVIDE	OR SUPPLIER	******			03	3/02/2012
		TER OF RHEA CO	UNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321		
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F 25	6. Ur 23, th holes	ere were five (5)	bathroom for room 22 and approximately 3-5 inch tissue holder and the	F 2	How will the corrective action to accomplished for those resident found to have been affected by deficient practice?	·c	
280 S=D	8. Un 10-inc peelin ceiling with d 9. Un 2 to 3 The lir stains 10. Un the wa condition 11. Un the inte During Manage he state needed confirm stated 483.20(PARTIC	it "D" Hall common harea around the grand cracking putiles around a heark, black stains. It "D" Hall-Room inch holes around oleum was stained around the toilet. It "D" Hall-Room II, next to the room inch wall, next to the room inch wall, next to the room inch wall, next to an interview with ar and Director, or and the bathroom if to be completely and all of the afore Repairs would be d)(3), 483.10(k)(2) IPATE PLANNING	on shower-The upper, e ceiling on the wall had eint. Approximately four (4) eating unit were discolored 39 bathroom had four (4), d the toilet tissue holder. ed with dark, brownish 22 had a foot long hole in m's heating/air 24 had a 5 inch hole on bed "A." the facility's maintenance in 2/29/2012 at 11 a.m., faucet in Room 1 and 2 changed out. They both mentioned findings and ign right away." P. RIGHT TO IG CARE-REVISE CP	F 280	The Director of Maintenance will The findings of the weekly and mater pressure and protruding naresident bathrooms, and the mont outlet cover, flooring, and wall reto the Performance Improvement monthly for three consecutive momonthly for one year. The Performance Improvement Committee consisting Executive Director, Medical Director, Medical Director of Medical Records, Director of Medical Records, Director of Environmental Service Of Maintenance, Director of Social Director of Human Resources, Director of Food and Nutrition Ser Director of Admissions/Marketing the findings and make recommendate develop plans of action if any areas be non-compliant.	nonthly random il review of thly light fixture, wiew Committee onths, and mance ng of the ctor, d Care Nurse, process, process, and the rector of Rehabitector of Nursing vices, and will review attons and are noted to	3/23/1ª
	incapaci participa	tated under the la	aws of the State, to		The Dietary Manager updated For Resident #8 on 3/5/12 to remain to contine Health shakes and weekly weight	eflect	3123'112

STATEMENT OF D	EFICIENCIES	(V4) PROMERROUSE IED IN IT				
AND PLAN OF COR	RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE :	
		445494	B. WNG _		03	/02/2012
LIFE CARE CE	ER OR SUPPLIER		1 3	REET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321		
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A cominter physics and the legal and	nin 7 days after the norehensive assess indisciplinary team sician, a registere the resident, and o ciplines as determi , to the extent pra- resident, the residal representative; a	e plan must be developed e completion of the ssment; prepared by an that includes the attending d nurse with responsibility other appropriate staff in ned by the resident's needs, cticable, the participation of ent's family or the resident's and periodically reviewed to of qualified persons after	F 280	The RN MDS Coordinator updated Care plan for Resident #5 on 3/22/1 To reflect all current fall intervention. 2) How will you identify other in Having the potential to be affect the same deficient practice? The Resident at Risk Committee, in The Dietary Manager, Director of 1 Director of Social Services, and a F Therapist reviewed residents who has significant weight loss (5% and 13/6/12. Residents who are at risk for Loss have interventions care planner.	esidents ected by ncluding Nursing, Physical lave had 10%) on	3/23/12
by: Bas the f facili resid for o weig (Res revis resid multi 2/10/ and u susta from Subs on 2/	ed on observation acility's policy revity failed to revise the failed to revise the failed to revise the failed to four (4) reference (1) of four (4) reference (4) of four (4) reference (5) of failed (5) of failed (6) of faile	is not met as evidenced a, medical record review, ew, and staff interview, the the care plan for an at risk iencing impaired nutrition esidents reviewed for al sample of 24 residents ion, the facility failed to for one (1) of 24 sampled who had a history of lent sustained 7 falls from e facility 's failure to revise an resulted in the resident e of which resulted in harm elchair on 12/10/11. lent sustained another fall eelchair while in the dining		The RN MDS Coordinator and the A (RN) reviewed the care plans for res At risk for falls, and residents with realists on 3/20/12 to 3/23/12. Residents are risk for falls have care interventions. What measures will be put into place What systematic changes will you may to ensure that the deficient practice who trecur? The Resident at Risk Committee will Review residents with significant we Loss, or residents whose weights have Declined weekly and ensure that into Are in place and care planned per Mills The dietary manager or LPN/RN will the interventions for these residents in meeting minutes and resident's chart this meeting. This committee will meet per policy indefinitely.	planned planned or pake will light re reventions D order. I document n the during	3/23/12
The fi	ndings include:				-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 445494 03/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY LIFE CARE CENTER OF RHEA COUNTY DAYTON, TN 37321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 6 F 280 The Falls Committee will review residents At risk for falls weekly for three months, And ensure that MD approved interventions 1. Cross Refer to F325. Are in place and care planned. The RN will document the interventions for these residents in the meeting minutes and resident's chart Resident #8 was admitted to the facility on during this meeting. This committee will meet 7/24/09 with diagnoses which included weekly per policy indefinitely. The Falls Esophageal Reflux, Vitamin Deficiency, Senile Committee includes the ADON, MDS Nurse. Dementia, Insomnia, Constipation, Generalized Rehab Services Manager, Activities Director, Social Services Director, and Staff Development Pain, Visual Discomfort, Osteoporosis, Arthritis, 3/23/12 Coordinator. and Urinary Tract Infection (UTI). The most recent quarterly Minimum Data Set (MDS), dated 4) How will the corrective action be 1/24/12, coded Resident #8 as requiring Accomplished for those residents supervision (oversight, encouragement or cueing) found to have been affected by and dne person physical assistance with eating. Deficient practice? In addition, the 1/24/12 MDS indicated Resident #8 weighed 108 pounds (lbs.). The previous The Director of Nursing will present MDS, dated 11/3/11, coded Resident #8 as The findings of weekly significant weight loss review,

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requiring only set-up help and weighing 111 lbs.

Review of the resident's Weight Change History

revealed a weight of 119 lbs. on 8/5/11. Review

of Resident #8's care plan, developed 8/18/11,

revealed potential for weight loss r/t [related to]

leaving 25% or more at most meals and a goal

for her to lose no weight over the next 90 days

(11/30/11); Resident currently within her IWR

[Ideal Weight Range] of 99 -121 pounds. The

up at least quarterly, (4) Update food

care plan approaches were (1) Serve regular diet

as ordered by physician, (2) Milk TID [three times a day] with meals and fortified foods BID [two times a day], (3) Increase Vitamin C beverage BID, yogurt with supper, (3) Dietician and/or CDM [Certified Dietary Manager] to evaluate and follow

Resident #8 was observed with a thin frame

during initial tour on 2/28/12 at 1:06 p.m.

Event ID: 52YY11

Facility ID: TN7202

be non-compliant.

And the weekly resident at risk for fall review to the Performance Improvement Committee monthly indefinitely. The Performance Improvement

Committee consisting of the Executive Director,

Director of Environmental Service, Director

Of Maintenance, Director of Social Services,

Director of Admissions/Marketing will review

develop plans of action if any areas are noted to

the findings and make recommendations and

Director of Human Resources, Director of Rehab

Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and

Director of Medical Records,

Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse,

If continuation sheet Page 10139

3/23/12

CENTE	RS FO	R MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES		0	FO	ED: 03/14/20 RM APPROV NO. 0938-03
STATEMENT SND PLAN C	OF DEF	ICIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	SURVEY
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NAME OF P	ROVIDE	OR SUPPLIER			STREET ADDRESS CITY STATE TO SOLUTION		/02/2012
LIFE CAF	RE CEN	TER OF RHEA CO	UNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321		
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# F T 1 1 1 C C T T T T T T T T T T T T T T	preferand reported and reported and reported and reported and reported and reported and reveal of the reveal of th	acord. Report arian, (6) Weigh rent any trends for I stered Dietician], and by Physician. available. The caproach of 60 ml b0/11 w of the resident's ded a weight of 11 Nutritional Prograded "Intake declining Resident frequer in the resident's approach of Head on tray as of 9 was discontinued are balanced for a supplemental capain. Tof the Weight Cloth #8's weight consistent of the I con/Assessment for I med and I med I med and I med I	or food intake at each meal by decline to Physician and sident per facility protocol. Physician and RD and (7) Obtain lab work as Report results to Physician are plan was updated with Med Pass® BID x 21 days s Weight Change History 15.2 lbs. on 9/6/11. Review less Note dated 9/26/11, ing; average daily intake littly refusing her Med plement to Health Shake Continue to monitor abs as available." It care plan was updated lath Shake with each meal 1/27/11 and the Med lath Shake with each meal 1/27/11 and the Med lath iffied nutrition drinks to alories and protein for lange History revealed nationed to decrease to late 110.6 lbs. on Nutrition Data form, dated 11/14/11.	F 2	80		

STATEMENT AND PLAN OI	OF DEFIC	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20. 20	ULTIPLE C LDING	ONSTRUCTION	(X3) DATE S COMPL	
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		OR SUPPLIER	DUNTY		7824 F	ADDRESS, CITY, STATE, ZIP CODE RHEA COUNTY HWY ON, TN 37321		(*)
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	fortifies stimular Review Reside Ibs. on dated Note profile From Shakel [reside 108.4 lites document to the context of the con	or the Weight and #8's weight of 12/15/11. The 12/27/11, revea rogressive wt londified Foods] B TID. Will add int] has refused int #8's weight of the theory on 1/12/12 aumented on her rough the residuoss, no additional world in the residuoss, no additional world world in the residuoss.	ch. Request appetite ian." Change History revealed decreased further to 109.6 Nutritional Progress Note, led "Wt 109.6 # [pounds]; lessConsumes 50%, ID, Milk TID & H/S [Health lice cream as rt Med Pass supplements." continued to decline to leand to 102.0 lbs. on 2/3/12 Weight Change History, lent continued to experience and approaches were	F	280			
I I I I I I I I I I I I I I I I I I I	Review Program Process on a resonantal relation so the level operation of the level of the level operation of the level operation of the level operation of the level of	of the facility's in Overview: No by policy, dated sident's compreciplinary Team real status, as desight, hydration, ned, unless a retrates this is no exprevention and ment of any nut's care plan is of to remain currection, goals, and in interview with r (CDM) on 3/1/d the resident's	'Nutrition Intervention atrition Assessment 7/23/09, revealed "Based hensive assessment, the ensures that acceptable fined by parameters of and protein levels, is esident's clinical condition t possible. The emphasis d/or early detection of the tritional concerns. The leveloped and modified as nt with problem/concern d interventions." the Certified Dietary 12 at 6:30 p.m., she care plan wasn't updated er significant weight loss					

STATEMENT AND PLAN C	OF DE	ICIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE COMPI	
		2	445494	B. WI	NG_		0:	3/02/2012
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	on he 2. C Residente Services Residente Ser	of. Her diagnoses, Rheumatoid Vein Thrombosise, Rheumatoid Vein Thrombosise, Rheumatoid Vein Thrombosise, Rheuman Data led the resident tive skills, require e-to-surface trand chair or whee hadent on staff for oileting and bath seed the resident lance with dressident lance with dressident lower extremities are plan initiated ed the goal, "With proaches includer after supper moto bed after supper to bed in the supper to be supper	itted to the facility on es include Alzheimer's Arthritis, and history of s. Review of the most Set (MDS), dated 12/27/11, had severely impaired ed 2 person assistance with insfers (transfer between elchair), and was totally locomotion on and off the ing. The MDS also as requiring extensive ng and personal hygiene, ge of motion on both sides	F	280			

		WEDICAID SERVICES				OWR MC	<u>). 0938-03</u> 9
STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	
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	E CARE CENTER OF RHEA COUNTY		7824 RHEA COUN		ET ADDRESS, CITY, STATE, ZIP CODE 24 RHEA COUNTY HWY YTON, TN 37321	1 000	
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F 282 SS=G	the dare plan attacher Recommendation For forward to the presen They also verbally connot be left unattended documented as an applan. Review of the facility policy, documented, plan is reviewed throut treatment by the interest the most recent, upda fall reduction intervent incorporated as neces 483.20(k)(3)(ii) SERVI PERSONS/PER CARI	ntion was documented on d to the Incident Follow-up & m but was not brought t care plan dated 4/30/11. Infirmed the resident should if. This intervention was not approach on the current care s "Falls Management" "Procedure: e.) The care aghout the course of disciplinary team to assure ted, and resident specific tions have been asary into the plan of care." ICES BY QUALIFIED E PLAN or arranged by the facility		82 1)	What corrective action will be Accomplished for those residents found to have been affected By the deficient practice?		
	must be provided by q	ualified persons in resident's written plan of			The RN MDS Coordinator updated Care plan for Resident #5 on 3/20 To reflect all current fall intervention	12	3/23/12
i d	by: Based on record revie Certified Nursing Assis	is not met as evidenced w, staff interview, review of tant's (CNA) Daily Care			Staff Development Coordinator (R Care Guide utilization training wit Nursing Assistants on 3/22/12, wit On following fall precautions with At risk for falls.	h Certified h a focus	3/23/12
F	Suide, and the Inciden	t Follow-up & ns, the facility failed to care for one (1) of 24		2)	How will you identify other reside Having the potential to be affected the same deficient practice?		2
h fa R w tr	istory of multiple falls. alls from 2/10/11 to 2/1 Resident #5 indicated s vith a lift and two perso	The resident sustained 7 15/12. The care plan for staff transfer the resident on assist, and not to leave the while in the wheelchair in			The Staff Development Coordinate Completed mechanical lift(s) componed on Certified Nursing Assistants on The SDC educated facility associate how to check for falls. These associates of the coordinate of the coordinate of the staff of the	oetencies i 3/22/12. les on riates al services,	3/23/12

STATEM AND PLA	ENT OF DE	FICIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRUCTION		(X3) DATE SU COMPLE	
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F2 50 N	Revidocutarian safet meal room Seleep across whee safet safe	falls, one of which if a wheelchair on esident sustained her wheelchair witended. Indings include: Refer to F323. ew of the care planented the follow sfer with lift and the care with lift and the care while in wheelch while in wheelch while in wheelch in white in wheelch is and (3) do not leave of the CNA's and (3) do not leave while in wheelch while in wheelch in white in wheelch is it is a the care of in bed. Howelf is it is a the care of the	in the resident sustaining resulted in harm from a fall 12/10/11. Subsequently, I another fall on 2/15/12 thile in the dining room In, dated 4/30/2011, ving approaches: (1) wo (2) person assist for d or recliner after supper eave resident unattended in air. Daily Care Guide, dated in air. Daily Care Guide, dated in air. In room. Place resident in er lift with transfers, use at 10:14 a.m., revealed wheelchair, nodding off to ation cart on the short hall is station. Alarm on the resident. The Hoyer resident in wheelchair. #5 sustained a fractured er which resulted after a . The Incident Follow-up m dated 12/10/11, in dining room lying in	F 2	What system to ensure that not recur? The ADON (Visual audit of At risk for fall For three more manager, LPN audit monthly maintained on Education to see Plan of intervention and Improvement Control The Director of The Findings of the Medical Director of Admission of Medical Director Officer Director Director Director Director Director Director Director	Nursing will present weekly and monthly fall lit to the Performance ommittee monthly therease Improvement Committe Executive Director, r. Business Office Managordinator, Wound Care cal Records, ronmental Service, Director of Social Service an Resources, Director of and Nutrition Services, a sssions/Marketing will remake recommendations a action if any areas are no	ekly esidents as/guides ait s visual antitee. to the essary. estor ces, f Rehab of Nursing and view	3/23/12

TATEMENT ND PLAN O	OF DEFIC	IENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE :	
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s Caadd R dd oo S dd vii saa hee of sh	Forma 10:30 a was poor the dini in the filt found it was not unattended to make the standard the	ming back from ming back from ming back from ming back from me nurse (name followed by led ded in the dining sustaining a ming followed by led ded in the dining sustaining a ming followed by led ded in the dining sustaining a ming followed by led ded in the dining followed by left. Resident formendation From the ming form from her whom. The Incident form ming form the states she at Form date of the states she at Form date of the states of the ming former forme	the CNA, dated 12/10/11 at ted, "This morning when I in lunch break I walked by resident's name) was lying. I ran down the hall and e of nurse). The care plan eaving the resident ing room resulting in the fractured nose." #5 sustained bruises to her ch resulted after a fall from the fractured fractured nose." #5 sustained bruises to her ch resulted after a fall from the number of the Incident Follow-up form, dated 9/27/11 in the was being transferred when the Certified Nursing in the toward bed she 1., Resident #5 sustained the ent Follow-up & in dated 2/15/12, it was sitting in floor in front slid out." CNA "Witness id 2/21/12 at 3:52 p.m., king to the back to do new side dining room I sident) sitting in front of ared that she had slid out if if she was ok. She said nen ran to get help. Me ites assisted her." Falls Management" Procedure: e.) The care to the course of	F 282	DEPICIENCY		

	OF DEF CIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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	fall reduction interver incorporated as neous incorporated as neous An Interview conduct Nursing (DON) and (ADON), on 3/2/12 aresident was left una The DON and ADOI no longer works at trabout leaving the redining room, and nerisk. Further intervie at 3:30 p.m., with the confirmed the residence person assist by stat transfer the resident Director of Nursing (approximately 3:45 peverything on the CN to data. If there were	dated, and resident specific entions have been ressary into the plan of care." cted with the Director of Assistant Director of Nursing at 3:15 p.m., confirmed the attended in the dining room. N also revealed the CNA, who he facility, was reprimanded sident unattended in the eded further education on fall w with the ADON, on 3/2/12 e care plan in hand, ent was supposed to have 2 ff when using the lift to.				
SS=D	DEPENDENT RESIDENT RESIDENT RESIDENT RECEIVES IT MAINTAIN GOOD NUTRINIST REQUIREMENT BY: Based on group interectord review, the factoric review in the factoric review in the factoric review.	ARE PROVIDED FOR DENTS able to carry out activities of the necessary services to on, grooming, and personal is not met as evidenced rview, staff interview and cility failed to ensure that ed as scheduled for one (1)	F 312	What corrective action will be Accomplished for those residen found to have been affected By the deficient practice? Resident #22 received a shower As scheduled each Monday, We And Friday from 3/5/12 through These dates include 3/5/12, 3/7/3/9/12, 3/12/12, 3/14/12, 3/16/11 C.N.A. #7 received one on one of The Staff Development Coordin On 3/15/12 on completing show Notifying a supervisor if unable	by a C.N.A ednesday, 1 3/19/12. 12, 2, and 3/19/12. education by nator (RN)	. 3/23/12

	THE BIOTH	TE O MILDIONID BLIVICES			OWR	VO. 0938-05
AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
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	of 12 residents a The findings including group interests and poments and problem getting has supposed to not get it. The remore than once, after group, revealer body but need the body but need her limited her limited has been supported her body. Interview conducted her body and have ended her her limited her well assigned to provide her body on 3/2/12 confirmed they were giving showers. Stonducted an in-seconducted an in-seconducted to sign in.	ttending group, Resident #22. ude: erview conducted on 2/29/12 at ent #22 stated she had a ser showers. She stated she get a shower Monday and did sident also stated it happened Further interview conducted eled she can wash the front of diassistance with the rest. Ity Shower Schedule dent #22 was scheduled for ays, Wednesdays and Fridays. Onthly Flow Report" completed ang Assistants (CNAs) by Care" for February 2012, ent had not received showers and Monday, 2/27/12 ed on 3/2/12 at approximately NA #7, revealed she was a care for Resident #22 on The CNA stated she did not shower on Monday because	F 312	2) How will you identify other resi Having the potential to be affect the same deficient practice? Assistant Director of Nursing (F Completed an audit of resident s For timely completion on 3/21/1 Scheduled to have showers have Showers timely unless they have This was confirmed by the ADO Reviewing documentation on The "Monthly Flow Report" con By Certified Nursing Assistants Staff Development Coordinator Completed education with C.N.A 3/22/12 on completing showers, Notifying a supervisor if unable if Scheduled showers timely. Educa C.N.A's will occur as necessary will be reassigned if necessary to resident receives number of show scheduled per week are given. This education will also be comp upon orientation of new C.N.A's Staff Development Coordinator. 3) What measures will be put into p What systematic changes will you to ensure that the deficient praction not recur? The ADON (RN) will complete a audit for 3 months and monthly to resident shower completion by C. Education to C.N.A's will occur as The unit manager, LPN, will condu- Interviews with intercviewable residenting showers as scheduled	RN) showers 2. Residents received refused. N npleted (C.N.A's). (RN) A.'s on and to complete ation to . Showers ensure vers leted by the lace or u make ce will a weekly, hereafter, or timely N.A's. as necessary.	3/23/12

PRINTED: 03/14/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-037 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG 445494 03/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY LIFE CARE CENTER OF RHEA COUNTY DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION . (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 312 Continued From page 14 F 312 of 12 residents attending group, Resident #22. How will the corrective action be Accomplished for those residents The findings include: found to have been affected by Deficient practice? During group interview conducted on 2/29/12 at 3:30 p.m., Resident #22 stated she had a The Director of Nursing will present problem getting her showers. She stated she The findings of weekly and monthly "Monthly was supposed to get a shower Monday and did Flow Report" audit for timely resident shower completion to the Performance not get it. The resident also stated it happened more than once. Further interview conducted Improvement Committee monthly for one year. The Performance Improvement Committee after group, revealed she can wash the front of consisting of the Executive Director, her body but need assistance with the rest. Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Review of the Daily Shower Schedule Director of Medical Records, documented Resident #22 was scheduled for Director of Environmental Service, Director showers on Mondays, Wednesdays and Fridays. Of Maintenance, Director of Social Services, Review of the "Monthly Flow Report" completed Director of Human Resources, Director of Rehab by Certified Nursing Assistants (CNAs) Services, Director of Activities, Director of Nursing documenting "Daily Care" for February 2012, Director of Food and Nutrition Services, and Director of Admissions/Marketing will review revealed the resident had not received showers the findings and make recommendations and on 2/3/12, 2/6/12 and Monday, 2/27/12 develop plans of action if any areas are noted to (Monday). 3/23/12 be non-compliant. Interview conducted on 3/2/12 at approximately 4:15 pm., with CNA #7, revealed she was assigned to provide care for Resident #22 on Monday, 2/27/12. The CNA stated she did not give the resident a shower on Monday because she did not have enough time. Interview with the Assistant Director of Nursing (ADON) on 3/2/12 at approximately 8:45 a.m.,

confirmed they were having problems with CNAs giving showers. She also revealed the facility conducted an in-service on 2/2/12 regarding showers. The ADON stated facility staff were required to sign in. Review of the Inservice sign in sheet revealed CNA #7 was not on the list as

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE COMP	
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F 312	l and the same		F 31:	2		
F 315 SS≃D	having attended the in 483,25(d) NO CATHE RESTORE BLADDER	TER, PREVENT UTI,	F 31:	5		
33-0	Based on the resident assessment, the facilities resident who enters the indwelling catheter is resident's clinical condicatheterization was now ho is incontinent of the treatment and services infections and to resto function as possible.	's comprehensive ty must ensure that a the facility without an indicatheterized unless the dition demonstrates that excessary; and a resident eladder receives appropriate as to prevent urinary tract are as much normal bladder is not met as evidenced		What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? Resident #4 discharged on 3/7/12. Resident #5 completed antibiotic t For E-Coli as of 3/20/12 and show Signs or symptoms of infection. C.N.A # 5 received one on one edu And competency was completed By the Staff Development Coordin On personal hygiene care, includin Incontinent care for a resident on 3	herapy s no current ucation ator (RN) g proper /15/12.	3/23/12
	interview and policy re provide incontinent car	view, the facility failed to e in a manner to prevent for two (2) of 24 sampled		C.N.A # 3 received one on one edu And competency was confirmed By the Staff Development Coordin On personal hygiene care, including Incontinent care for a resident on 3/	ator (RN)	3/23/12
	The findings include:	2.5 4	etp1(2)	How will you identify other resident Having the potential to be affected the same deficient practice?	its by	*
		tant (CNA) #5 did not wash the urethral area.	U. CO. O.	Assistant Director of Nursing (RN) And Unit Manager (LPN) observed C.N.A's providing incontinent care Residents receiving antibiotic treatn	of nent for	8
	with results of Escheric	e, completed on 1/25/12, hia Coli (E-Coli- a colon). NA.	E-Coli on 3/22/12. C.N.A's provide Care in a manner to prevent urinary Tract infections.	d incontinent	3/23/12
	bacillus, an indicator of Enterococcus faecalis (intestinal tract), mixed f treated with antibiotic th			Staff Development Coordinator (RN Completed education and competent With C.N.A's on 3/22/12 on persons Hygiene care, including proper incomplete the control of the control	cies al	
				Care for a resident.	nancut	3/23/12

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET	Land Control of the C
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RHEA COUNTY STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY	02/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
2. Observation on 3/1/12 at 10:10 a.m., of incontinent care for Resident #5, revealed CNA #3 df not separate the labia and wash the ureth real area. Observation and record review revealed the resident had an indevelling catheter. Further record review revealed of an evaluation of two (5) days. The Physician's Progress Notes dated 2/14/12, documented, "E-Coli UTI, P (Plan): Feminine hygiene education". During an interview with CNA #3 on 3/2/12 at 11:25 a.m., she confirmed she did not separate the labia to clean the resident's urethral area. Interview with the Director of Nursing (DON) on 3/2/12 at 11:30 a.m., confirmed the CNAs did not perform correct incontinent care. She stated, "staff are suppose to separate the labia, clean down both sides of the urethal area and then down the middle, front to back, using a clean towel each time." F 323 4SS=G The fadility must ensure that the resident The progress Notes dated 2/14/12, documented, "E-Coli UTI, P (Plan): Feminine hygiene clean towel each time." F 323 4SS=G The fadility must ensure that the resident F 315 What measures will be put into place or What systematic changes will you make to ensure that the place or What systematic changes will you make to ensure that the place or What systematic changes will you make to ensure that the place or wint as well as to ensure that the place or What systematic changes will be put into place or what systematic changes will prove the sure in summer to resure that the place or what systems consumers that the place or What systems changes will on the spar will not recur? The ADON (RN) will complete a weekly Random audit for 3 monlts and monthly for one year of incontinent care for residents by C.N.A's. These observations will occur for 5 residents on each hall, and the audit for 7 monlts and monthly for one year of incontinent care for residents by C.N.A's. These observations will occur for 5 residents on each hall, and the audit for 7 monlts and monthly for one year of incontinent care for residents by C.N.A's. The	3/23/12

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		_	
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	2. Observation and incontinent with resident has record revion 2/9/12, was treate twice a day. The Physic documents hygiene ed. During an in 11:25 a.m., the lab a to interview with a state of the physical and interview with a staff are	at care for Resister a. In and recorded an indwelliew revealed with results and with Macro y for five (5). Cian's Progreed, "E-Coli Loucation". Interview with the Direct and a.m., confirm the confirmation of the confirmatio	/12 at 10:10 a.m., of sident #5, revealed CNA elabia and wash the direview revealed the ling catheter. Further a urine culture, completed of E-Coli. The resident bid 100 milligrams (mg),	F	315	How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly and monthly "Incontinent Care Audit" for timely resident shower completion to the Performance Improvement Comonthly for one year. The Performance Improvement Comconsisting of the Executive Director, Medical Director, Business Office M. Development Coordinator, Wound C. Director of Medical Records, Director of Environmental Service, D. Of Maintenance, Director of Social Sc. Director of Human Resources, Director Services, Director of Activities, Director of Food and Nutrition Service Director of Admissions/Marketing will the findings and make recommendation develop plans of action if any areas are be non-compliant.	mmittee mittee anager, Staff are Nurse, irector ervices, or of Rehab tor of Nursin es, and I review		
F 323 SS=G	towel each Review of the Hygiene Ca documents, labia and wadownward for 483.25(h) FHAZARDS/	time." he facility's pare for the Fe , "Procedu ash urethral from front to I REE OF AC SUPERVISIO	olicy entitled, "Personal male Resident", ıral Steps: 16. Separate area first wiping pack".	F 32	:3				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 445494 03/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF RHEA COUNTY 7824 RHEA COUNTY HWY DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 17 F 323 environment remains as free of accident hazards What corrective action will be as is possible; and each resident receives Accomplished for those residents found to have been affected adequate supervision and assistance devices to By the deficient practice? prevent accidents. An RN reviewed the current fall Interventions for Resident #5 on 3/20/12 And confirmed the interventions Are documented on the care plan, C.N.A. This REQUIREMENT is not met as evidenced Care guide, and these interventions are in place. 3/23/12 by: Based on observation, staff interview and record The LPN Unit Manager educated C.N.A's review, and review of the Falls Policy, the facility Who care for Resident #5 on 3/22/12 failed to ensure one (1) of 24 sampled residents, On the residents current fall interventions And how to utilize the "C.N.A Care Guide" Resident # 5, who had a history of multiple falls, Daily to ensure current interventions are being was not left unattended when up in wheelchair, 3-23-12 Followed. and failed to ensure two staff assisted for safety when transferring the resident using a lift. The How will you identify other residents resident sustained 7 falls from 2/10/11 to 2/15/12. Having the potential to be affected by The resident sustained a fractured nasal septum the same deficient practice? and fractured left index finger during a fall on 12/10/11 while unattended in dining room, and Assistant Director of Nursing (RN) received bruises to her upper extremities during a And Unit Manager (LPN) reviewed the fall when staff transferred the resident with one Current interventions, care plans, and C.N.A care guides for residents at risk person assist instead of two, on 9/27/11. In For falls on 3/22/12. Interventions are in place, addition, the resident sustained another fall from And the C.N.A care guide and resident the wheelchair while left unattended in the dining 3-23-12 Care plans are congruent. room, on 2/15/12. This failure to provide adequate supervision to prevent and/or reduce The Staff Development Coordinator falls resulted in harm to Resident #5. educated C.N.A's on 3/22/12 on how to utilize the "C.N.A Care Guide" for The findings include: residents at risk for falls daily to ensure current interventions are being followed.

Sound

ORM CMS-2567(02-99) Previous Versions Obsolete

Resident #5 was admitted to the facility on

8/31/06. Her diagnoses include Alzheimer's

disease, Rheumatoid Arthritis, and history of

Deep Vein Thrombosis. Review of the most

revealed the resident had severely impaired

recent Minimum Data Set (MDS), dated 12/27/11,

Event ID: 5ZYY11

Facility ID: TN7202

The Interdisciplinary Team consisting

Of the Director of Nursing, MDS RN Coordinator,

Activities Director, Rehab Services Manager,

Dietary Director, and Social Service Director

On the need for timely and accurate updating of

Resident care plans for residents who are at risk For falls, or who have experienced falls.

Were educated by the Executive Director

If continuation sheet Page of 36

			THE DIOTHO GENTAIGES			OMB	NO. 0938-C.
STATEMENT AND PLAN O	OF DEFIN	CIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE (
			445494	B. WING_	·	0.3	3/02/2012
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EII E OAN	CE CENT	ER OF RHEA CO	UNTY		DAYTON, TN 37321		
(X4) ID		SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TON	
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			***************************************		- All residents are assessed on admission	on for fall	
F 323	Contir	nued From page	18	F 323		t risk for	1
	cognit	ive skills, require	ed 2 person assistance with	, 52.	Falls" will be placed in the Fall Risk	program.	3/23/12 •
	surfac	e -to-surface tra	nsfers (transfer between	1			1
	bed a	nd chair or whee	lchair), and was totally	3	What measures will be put into place	or	
	depen	dent on staff for	locomotion on and off the	1	What systematic changes will you ma	ke	
	unit, to	ileting and bath	ing. The MDS also	i	to ensure that the deficient practice wi	111	
	assess	sed the resident	as requiring extensive		mot recur.		
	assist	ance with dressi	ng and personal hygiene,		The Unit Managers (RN) will complete	te a weekly	1
1	and wi	th impaired rang	ge of motion on both sides		audit of residents at risk for falls for 4	weeks, then	r
	of her	lower extremitie	S.		monthly thereafter.		
	01				This audit will include reviewing the	are plans	
	Obsen	vation on 2/29/12	2 at 10:14 a.m., revealed	1	And C.N.A care guides for these resid	ents, and	
1	the res	ident sitting in a	wheelchair (w/c), nodding		Visually reviewing that interventions a The Unit Managers will educate C.N.	are in place.	1
	chort is	lieep beside the	medication cart on the		New interventions are added for reside	nts at	1
1	on whe	all across from t	the Nurse's station. Alarm	1	Risk for falls. The Staff Development	Coordinator	.
	OII WITE	eichail, allache	d to the resident.		(RN) will educate new C.N.A associate	es upon	
	The Fa	ille Caro Blan de	ated 4/30/11, identified the		Orientation of how to utilize C.N.A Ca	are Guides	1 1
	probler	n "Resident is	at high risk for falls r/t		To ensure that interventions for falls ar	re followed.	3 23/12
į	(related	to) impaired m	obility, frequent falls,	4)	How will the corrective action be		
	impaire	d balance coon	itive deficits and muscle	"	Accomplished for those residents		
	weakne	ess." Although ti	he resident was assessed		found to have been affected by		1 1
	with se	vere cognitive in	npairment, the falls care		Deficient practice?		1
	plan ren	vealed the follow	ring approaches: 1)				
	Person	al alarm in bed a	and chair. Check		The Director of Nursing will present		1
	placem	ent and function	every shift, 2) Transfer	l i	The findings of weekly and monthly "Falls" audit for intervention compliance	lesident at R	lisk for
1	with lift	and 2 person as	sist for safety, 3) Assist	l i	to the Performance Improvement Comp	z mittee	1 1
1	with pos	sitioning, transfe	rs, ambulation as		for one year. The Performance Improve	ment] [
1	necessa	ary or as reques	ted by resident, 4) Assist		Committee consisting of the Executive I	Director,	
t	to bed c	or recliner after s	upper meal.		Medical Director, Business Office Man	ager, Staff	
					Development Coordinator, Wound Car	e Nurse,	
l	In additi	ion, the following	approaches were added		Director of Medical Records,	22	
la	as the n	esident continue	d to fall: 5) Do not leave	Ì	Director of Environmental Service, Director of Social Service		
			oom while in w/c on		Of Maintenance, Director of Social Serv Director of Human Resources, Director	of Rebah	
16	5/29/11	, 6) Resident to	be put to bed after		Services, Director of Activities, Director	r of Nureina	
8	supper o	on 9/2/11 , 7) Ho	yer lift with 2 person [lift]		Director of Food and Nutrition Services	and	1
	on 9/29/	11, 8) Educated	staff on fall risk on		Director of Admissions/Marketing will i	review	' 1
1	2/12/11	1, 9) Place resid	lent in recliner or bed	-	the findings and make recommendations	s and	
V	vnen in	room on 12/29/1	11 , and 10)For trial		develop plans of action if any areas are i	noted to	Startin.
					be non-compliant.	1	3/23/12:

PRINTED: 03/14/2012 FORM APPROVED

STATEMENT	T OF DEFI	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB	NO. 0938-6
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find AR 11 dd from a with a	period bed aff dinner provide training the resident discontification from the fracture 12/10/1 Resident 12/11/1 "A resident falls". Review of Recommendation for falls and the falls and the falls and the falls are the falls and the falls are the falls and the falls are the falls ar	ter lunch for reson 2/21/12. The evidence demonstrate of for Fall Risk of ident's care plate proach/intervent unattended in inued on 12/29 as wheelchair in the dher nose and 1. In # 5's Fall Risk dent's score as 1. According to ent who scores of the facility's intended in the facility's intended in the facility's intended in Formal Resident #5 for 2/10/11 and 2/1 nose and Left occurred on the facility's intended in the Nurse's non, revealed, "If dining room flow for the facility is included. Blee Steri-strips apght and left fore entimeter) skin Clenz and steri-Nurse document	ceived from therapy, put to st period and back up for the facility was unable to constrating the staff received in 12/12/11 as outlined in in. Intion, "Do not leave the proom while in w/c" was	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SU IDENTIFICATIO		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S	
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	24 hours and ir next finger afte Review of the li Recommendati documented, "I floor face down forehaad and si protocol and x-r Taken: Upon ir needed further Education one-t The "Witness St CNA, dated 12/"This morning will unch break i wa (resident 's nandown. I randow (name of nurse) by leaving the reroom resulting ir fractured nose." Review of the Radocumented, "Cforehead, attentis Slight Deviation fowards the Right Deviation for the Physician's I at 1535 (3:35 p.n. with head lacerat linear) X-rays	eft (L) finger, Neuroche nmobilize (L) index fing	1, 1, lying in ng reated per ins/Actions involved follow-up: seted by the cumented, from n and r face e nurse i followed e dining g a 2/10/11, on sion: stum attion ame, um " 2/13/11 cent fall inger sal	F 32	3		

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r c s a (() n ri	Interview 3:00 (LPN) revea alarm prese his do 12/10 no do: attach Review Follow documeresider B. 9/2 The N. document oom, of Bed straight and sho completed to 12/10	o.m., with the Lie that assessed ied he could not was on the resint in the dining recumentation in the dining recumentation of the dining recumentation of the dining the dining the 12 months of the Nurses Notes dat ented, "CNA stressident was lying Lift during the 12 months of the dining on bulder on foot realing of months of the dining th	con 3/2/12 at approximately censed Practical Nurse the resident after this fall, a remember if the chair dent or if anyone else was room. The LPN reviewed the Nurse's Notes, dated in, and confirmed there was the alarm sounding or being int. Notes and Incident endation form, revealed no alarm being present on the 1/10/11 fall. In ed 9/27/11 at 7:35 p.m., ated Resident fell out of insfer. When I entered ing on back in floor in front itioned on back, both legs in foot rest of lift, left arm est of bed-side table. C/O Redness and bruising upper extremities) and ury noted. No S/S eture. BP (Blood Pressure) e) 96.1m Pulse 110. R	FS	323				
(I w C "F si in	Respirate of the control of the cont	ations) 20. Resing to bed. If 1 at 4:00 p.m. at sitting in floor pright, both legs ated, Assisted to be was trying to	ident assisted from floor to						

DEPAR CENTE	TMENT OF HEALTH A	AND HUMAN SERVICES MEDICAID SERVICES			PRINT FO	ED: 03/14/20
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F 323	Continued From pag incident."	e 22	F 323		76	
d d a b n first s S h	"Resident sitting in flot Sitting upright, legs for Spoke with daughter requests seat-belt tono injury. Denies pay wheelchair in room." E. 6/27/11 at 9:00 p.1 "Resident witnessed I Assistant) sliding out this Nurse enter sitting upright on butto No injury noted " F. 9/1/11 at 7:20 p.m. " "Resident sitting in flot position in front of wheelchair in front of wheelchair. I assisted back to w/c 3. 2/15/12 at 3:00 p.m. CNA "Witness Statem at 3:52 p.m., document at 3:52 p.m., document at 3:54 p.m., document of her wheelchair. I as the said she was not here and she was not here and she was not here."	by CNA (Certified Nursing of wheelchair (w/c) to floor. red room, resident was ocks in floor in front of w/c. or in hallway in a sitting telchair, back against chair, niury noted, denied pain				
do	ollow-µp & Recomme	rse's Notes and Incident ndation Form, revealed no arm being present on the		*		

residen during fall on 2/15/12. Also, there was

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 03/14/201 RM APPROVE IO: 0938-039
TATEMENT ND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S	URVEY
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in the state of th	the Nurse's Notes. The directly from a note on noted on 2/16/12 at 03 An Interview conducte Nursing (DON) and As (ADCN) on 3/2/12 at 3 resident was left unattered and should not have be also revealed the CNA the facility, was reprimaresident unattended in needed further education of the country of the cou	the 2/15/12 fall reflected in the Nurse's Notes went 1/1/1/12 at 12:20 p.m to a 2:00 a.m. Id with the Director of sistant Director of Nursing 15 p.m., confirmed the ended in the dining room the ended in the dining room the ended about leaving the the dining room, and the ended about leaving the the dining room, and the on on fall risk. They also cation was done with the vidocumentation that the interview with the 0 p.m., with the care plan resident was supposed to 1 staff when using the lift to did confirmed that the ly alert enough to ask for the Director of Nursing 10 poximately 3:45 p.m., she gon the CNA Daily Care on the GNA Daily Care on the GNA Guide would elive a "Daily Care"	F 323			

provides them with direction based on the care plan. The following was listed on the CNA's "Daily Care Guide," dated 3/1/12, for the resident:

1) Do not leave resident up in w/c unattended and

Place resident in recliner or bed. The aforementioned approaches on the CNA's "Daily

AND PLAN C	OF DE	CIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The Company of the Co	TIPLE CONSTRUCTION	(X3) DATE S		
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NAME OF P	ROVIDE	R OR SUPPLIER				03	02/2012	
LIFE CAR	RE CEN	TER OF RHEA	COUNTY	s	TREET ADDRESS, CITY, STATE, ZIP CODE 7824 RHEA COUNTY HWY DAYTON, TN 37321			
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in F	Care current a.m. stated in her care paddre that or meal to outside this was this appropriate that awaren he resident awaren he resident awaren he resident this was this appropriate that awaren he resident this was this appropriate that awaren he resident that a waren he resident that	nt care plan incting approach with CNA #3 as I the resident viroom. Further plan nor the Chased any of the courred outside imes as well at e of her room. on interview viron should never place proach was act in the CNA assisted of the cours and lack of the cours and lack of the facility's revised date of the facility's revised date of the course of the facility's revised date of the facility's revise	twith the resident's most terventions. In addition to the in, interview on 3/1/12 at 10:10 ssigned to the resident, she was not to be left unattended rmore, neither the resident's NA's "Daily Care Guide" eresident's numerous falls e of the facility's scheduled is the falls that occurred with the DON and ADON, the in have been left alone, but id on the care plan. Although ided to the CNA "Daily Care signed to the resident was bach. This lack of of communication resulted in it alone again in the dining another fall after the fall with its Falls Management Policy, of December 2006, rdisciplinary plan of care will sented, reviewed and	F 32	3			
th in up int ne of	urrent interventian Der irougho terdisco dated, terventicessai Falls I	safety needs a tions Assest velopment: e) but the course iplinary team to and resident ions have beery into the plar h.) The charge	to reflect each resident's and fall reduction assent of Fall Risk & Care The care plan is reviewed of treatment by the o assure the most recent, specific fall reduction in incorporated as of care Management and the nurse will gather and and data as possible related					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEF CIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 445494 03/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF RHEA COUNTY 7824 RHEA COUNTY HWY DAYTON, TN 37321 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 323 Continued From page 25 F 323 to the fall, take note of the environment in which the fall occurred, and record any potential causal factors and j.) The charge nurses will review and update the care plan as needed to reflect the resident 's present mobility, safety needs, and will communicate fall reduction interventions to care givers on the unit and in shift report . . . Follow-Up Falls: h.) The Fall Reduction Committee (a sub-committee of Performance Improvement) will review fall trends, analyze data, and determine the need for action plans designed to minimize the risk of falls." F 325 483.25(i) MAINTAIN NUTRITION STATUS F 325 UNLESS UNAVOIDABLE SS=D What corrective action will be Accomplished for those residents Based on a resident's comprehensive found to have been affected assessment, the facility must ensure that a By the deficient practice? resident -(1) Maintains acceptable parameters of nutritional Physician reviewed resident nutritional status status such as body weight and protein levels, And the Resident at Risk Committee unless the resident's clinical condition recommendation on 3/7/12 for Resident #8. The physician elected to continue demonstrates that this is not possible; and Weights weekly, and health shakes with meals. (2) Repeives a therapeutic diét when there is a Physician denied request for new order for nutritional problem. Appetite stimulant at this time. The Resident At Risk Committee consists of the Director Of Nursing, Dietary Manager, Wound Care Nurse, Therapist, Social Worker, and Dietician. 3:23-12 This REQUIREMENT is not met as evidenced Based on observation, medical record review, the facility's policy review, resident and staff interview, the facility failed to follow up timely with Res 5 sample the Physician on a recommendation of an

FORM CMS-2567(02-99) Previous Versions Obsolete

Appetite Stimulant for an at risk resident already experiencing impaired nutrition for one (1) of four (4) residents reviewed for weight loss out of a total sample of 24 residents (Resident #8).

Event ID: 5ZYY11

Facility ID: TN7202

If continuation sheet Page

STATEMENT AND PLAN O	STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		CIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	The fi Resid 7/24/0 fimited and S Minim Resid encou physic 1/24/1 pound and a to her she or weigh Reside during Review reveals below) -119.0 -115.2	9 with diagnose I to, Esophagea I to I t	itted to the facility on swhich included, but not I Reflux, Vitamin Deficiency, The most recent quarterly DS), dated 1/24/12, coded ng supervision (oversight, eing) and one person ith eating. In addition, the d Resident #8 weighed 108 is a three (3) lb. weight loss by of Daily Living according dated 11/3/11, which coded up help with eating and rived with a thin frame 28/12 at 1:06 p.m.	F3	25 2)	How will you identify other residents Having the potential to be affected by the same deficient practice? The Resident at Risk Committee, consi The Director of Nursing, Dietary Mana Wound Care Nurse, Therapist, Social Vand Dietician reviewed the current state residents with weight loss on 3/6/12. The Resident at Risk Committee contact the physician on 3/6/12 for 12 (twelve) and on 3/7/12 for 3 (three) residents an and received clarification for the plan of these residents. The Executive Director educated the Resident Committee on 3/20/12, consisting of the Director Of Nursing, Dietary Manager, Wound Cartherapist, Social Worker, Dietician, an Unit Manager that an LPN Unit Managis to contact the residents physician and new orders or clarification orders for rewho have received recommendations by Resident at Risk Committee within 24 to the committee meeting. This communwill be documented in the nurses notes.	ger, Worker, us of cted residents, d reviewed of care esident at e Nurse, d LPN er receive sidents y the rours nication	3/23/12	
-	-109.6 -108.4 -102.0	lbs. on 11/4/11 lbs. on 12/15/11 lbs. on 1/12/12 lbs. on 2/3/12				All new admissions will be reviewed we 4 weeks by Resident at Risk committee. will be reviewed by Dietary Manager. I will be reviewed by Resident at Risk co if a change in condition has occurred the nutritional status.	All readmits mmittee		
i di	9/26/11 daily int ner Med Shake	, revealed, " Int ake 55%. Resid I Pass®. Chang IID [three times	al Progress Note dated ake declining; average dent frequently refusing ge supplement to Health daily]. Continue to & [and] labs as available."			*		3 <i>[2</i> 3 <i>]</i> [2	

STATEMENT	OF DEC	MEDICARE &	MEDICAID SERVICES					RM APPROV NO. 0938-03	
AND PLAN OF CORRI		ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ME OF PROVIDER OR SUPPLIER						/02/2012		
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F T m w F V re	There with a provid Passo Shake provid weigh Review Collector reveals [estable] [estable] [signific Shakes food Bifollow meetin ninutes cokie Physical Physi	n approach of Held on tray as of Dead on the Supplemental of Suppleme	acare plan was updated ealth Shake with each meal 9/27/11 and the Med ed. Med Pass and Health ortified nutrition drinks to calories and protein for Data form, dated 11/14/11, insumption < est. di note progressive, not sig loss over time. Receives is a day] Fort [fortified] ay] & Milk TID. F/U ident At Risk] mtgs eview of the RAR meeting I revealed "Add fortified ist appetite stimulant from the Note, dated 12/27/11, bunds]; Note progressive 0%, FF [Fortified in the Item of the Item of the Item of Item of the Item of Item	F	3)325	and the partition place of	e I not recur? sting of ger, Vorker, isk r the the thours nication	3 33/12	

restorative nursing assistant, reviewed by the MDS nurse, and then entered into the facility's electronic system by the DM or Medical Records Nurse. They also explained the DM generates a report identifying residents with significant weight loss which is discussed during the RAR meetings

CENTERS F	OR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 03/14/201 RM APPROVE NO. 0938-011	
ND PLAN OF COR	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: 445494 AME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RHEA COUNTY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(X2) ML A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX			ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP 7824 RHEA COUNTY HWY DAYTON, TN 37321 PROVIDER'S PLAN (EACH CORRECTIVE, CROSS-REFERENCED TO	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	(X8) COMPLETION DATE	
held DOI Wood add decided Reverties Resided Reverties Re	N, Wound Care Nicker, DM, and the I ition, they stated R lining after her fractive of the Incident commendation Forr ident #8 fell and statute. iew of the facility's rvention Program C itoring," dated 7/23 dent who experience is gnificant weight the change is assess disciplinary Team. a weight change h ssment/progress n Flan team addres in loss/poor intake g needs if indicated surable goals, indicated surable goals, indicated intrition progress n ges, plan of action,	Attendees included the brse, Therapy, Social Dietician if possible. In esident #8's weight started ture in August 2011. Follow-Up & n, dated 8/6/11, revealed istained a right femoral policy entitled "Nutrition overview: Weight 1/09, revealed "Any less an unplanned weight change, or undesirable sed and monitored by the Each identified resident as a current nutrition ote. The Interdisciplinary ses the root cause of the or weight gain, assesses of provides realistic and lates specific and lons, and more as needed.	F3		Il present eview List/ Risk Meeting" audit ement Committee ment Committee Director, Office Manager, Staff Wound Care Nurse, s, Service, Director f Social Services, es, Director of Rehab ies, Director of Nursing on Services, and keting will review	3/23/12	

FORM CMS-2567(02-99) Previous Versions Obsolete

Resident #8 experienced 8.3% weight loss between 11/4/11 - 2/3/12 (approximately 90 days) and experienced 5.4% weight loss between 1/12/12 - 2/3/12 (less than 30 days).

Even though the resident continued to experience weight oss, as of 3/1/12, no follow up was done in reference to a response from the Physician to the appetite stimulant recommended on 12/5/11. This was 88 days later with no response. In

Event ID: 5ZYY11

Facility ID: TN7202

If continuation sheet Page 346134

					PRINT	TED: 03/14/2012
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RHEA COUNTY	8	Į	1000			
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nutrition progress notes in the resident's medica 11 and no modifications of care since 12/27/11. 2, the resident weighed 1 increase since 2/3/12). 2, the resident weighed 1 increase since 2/3/12). 3, the resident weighed 1 increase since 2/3/12). 4, the resident weighed 1 increase since 2/3/12). 4, the resident weighed 1 increase since 2/3/12). 5, the resident weighed 1 increase since 2/3/12). 6, the re	I record occurred 103 lbs (one 103/2/12 at a lot of possible for lant was uring at 1:15 p.m., ever ate all cream and I Dietary they punds with le for ions made. /2/12 at We get a " ENT an provide a pent and			What corrective action will be Accomplished for those residents found to have been affected By the deficient practice?		
	COCARE & MEDICAID SE (X1) PROVIDERATION DENTIFICATION OF PELIER RHEA COUNTY DEFICIENCY MUST BE PRECEDENT OF LICENCY OR LSC IDENTIFYING IN The resident's medical progress notes in the resident's medical progress in the resident weighed 1 increase since 12/27/11. At the resident weighed 1 increase since 2/3/12). The resident weighed 1 increase since 2/3/12). The resident on 3/2/12 increase since 2/3/12). The food is nearly important if the appetite stimulation of the resident on 3/2/12 increase in the resident on 3/2/12 increase i	IDENTIFICATION NUMBER: 445494 PPLIER RHEA COUNTY IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) From page 29 Inutrition progress notes were in the resident's medical record 11 and no modifications occurred of care since 12/27/11. In the resident weighed 103 lbs (one increase since 2/3/12). It with the Physician on 3/2/12 at the communicated he has a lot of collow and it's nearly impossible for ober if the appetite stimulant was the him for resident #8. During the resident on 3/2/12 at 1:15 p.m., The food is okay I never ate all the resident on 3/2/12 at 1:15 p.m., The food is okay I never ate all the resident on 3/2/12 at 2:00 p.m., they hursing Unit Manager rounds with weekly and is responsible for ock on any recommendations made. The program of the post of the program of the post of the program of the on for appetite stimulant." TION CONTROL, PREVENT ENS In testablish and maintain an only Program designed to provide a and comfortable environment and the development and transmission	A BUIL A SPELIER RHEA COUNTY A MANUAL ATTEMENT OF DEFICIENCIES ID PREFIX TAG A TORY OR LSC IDENTIFYING INFORMATION) Tom page 29 nutrition progress notes were in the resident's medical record 11 and no modifications occurred of care since 12/27/11. A the resident weighed 103 lbs (one increase since 2/3/12). Tiew with the Physician on 3/2/12 at the communicated he has a lot of ollow and it's nearly impossible for other if the appetite stimulant was the him for resident #8. During the resident on 3/2/12 at 1:15 p.m., The food is okay I never ate all ventire life. I like the ice cream and ive." Bay with the Dietician and Dietary on 3/2/12 at 2:00 p.m., they Nursing Unit Manager rounds with weekly and is responsible for ck on any recommendations made. The program designed to get a the Physician on the on for appetite stimulant." TION CONTROL, PREVENT TION CONTROL, PREVENT Tens Tet stestablish and maintain an only Program designed to provide a and comfortable environment and the development and transmission	A STREE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDING 445494 A BUILDING B. WING PREFIX TREE RHEA COUNTY A STREE RHEA COUNTY IDA IDA IDA IDA IDA IDA IDA ID	INCARE & MEDICAID SERVICES ES CX1 PROVIDERSUPPLIERCILIA DENTIFICATION NUMBER: A BUILDING	INCARE & MEDICAID SERVICES OMB STREET ADDRESS, CITY, STATE, ZIP CODE 7824 RIEA COUNTY INDIANARY STATEMENT OF DEPICIENCIES DEPICIENCY MUST DE PRECEDED BY PULL ATORY OR LSC IDENTIFYING INFORMATION) TOM page 29 Inutrition progress notes were in the resident's medical record 11 and no modifications occurred of care since 12/27/11. 2, the resident weighed 103 lbs (one increase since 2/3/12). Identify if the appetite stimulant was in him for resident #8. During the resident on 3/2/12 at 1:15 p.m., The food is okay I never ate all yentire life. I like the ice cream and we." BY WITH THE PONY OF JULY 12 to resident weighed 103 lbs (one increase since 1/2/27/11). The resident on 3/2/12 at 1:15 p.m., The food is okay I never ate all yentire life. I like the ice cream and we." BY WITH THE PONY OF JULY 12 to repeat the properties of the

(a) Infection Control Program

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		100	(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-03 SURVEY PLETED		
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To by Book Merwa	The far Program (1) Invite (2) De should (3) Ma actions (5) Pre (1) Why determ prevent isolate (2) The communisolate (2) The communisolate (3) The hands in and who rofession (2) Chine Person fection (3) The hands in and who rofession (3) The hands in and who rofession (3) The hands in and who rofession (3) The range of the faction (3) The range of the ra	am under which restigates, control facility; cides what proced to applied to all intains a record is related to infect eventing Spread en the Infection lines that a resident the spread of inthe resident. In facility must promit the resident enter the contact with the resident enter the enter the contact with the resident enter the enter	olish an Infection Control it - ols, and prevents infections edures, such as isolation, in individual resident; and of incidents and corrective tions. of Infection Control Program tent needs isolation to infection, the facility must onibit employees with a or infected skin lesions residents or their food, if mit the disease. uire staff to wash their resident contact for which ed by accepted store, process and prevent the spread of not met as evidenced taff interview and review	F4		The Staff Development Coordinator (R Completed one on one education with LPN # 2 on 3/15/12 on "Infection Control during Medication Administration". This included educating Remove gloves and wash hands after Administering medication to a resident With a gastrostomy tube before adjusting Clothing and moving equipment To prevent the spread of infection. The Staff Development Coordinator (R Completed one on one education with LPN # 1 on 3/15/12 on "Infection Control during Medication Administration". This included educating Remove gloves and wash hands between Administering eye drops to each eye For residents with orders for eye drops. To prevent the spread of infection. How will you identify other residents Having the potential to be affected by the same deficient practice? LPN Unit Managers observed LPN nurses administer medication to residents Gastrostomy tubes on 3/20/12 to 3/21/1 Nurses administered medication to these residents appropriately. LPN Unit Managers observed eye drop Administration to residents with physicion Orders for eye drops on 3/20/12 to 3/22/Nurses administered eye drops appropriated	N) on to on to on sing with 2. e	3/23/12

			ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 03/14/2012 RM APPROVED IO. 0938-0394
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TAG		REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
F 441	#9) a (1) res twenty	ident (Unsampl four (24) samp	ninistering eye drops for one ed Resident #1) from		141 3)	What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will a The Assistant Director of Nursing (ADO Will complete a weekly audit of medicat	N)	
	Practic medic Reside was w tubing abdom	oted on 3/2/12 at all Nurse(LPN) ation through the ation through the ation through the ating when she and equipment, linal binder, adjuster removing	at 11:05 a.m., Licensed #2 administered a e gastrostomy tube for removing the gloves she e touched the gastrostomy she fastened the usted the clothing and bed her gloves and using hand			Administration technique for residents With orders for gastrostomy tubes, and e Drops installation for three months, then monthly for one year. The ADON Will audit to ensure that proper infection Control technique is being followed.	ye	3/23/12
Journal De Constitution	An obs LPN # Reside changi instillin touche	ervation on 2/29 I administered on #1's left and her gloves and the first drop in the medication and lower eyelidervalle.	9/12 at 4:07 p.m. revealed eye drops to Unsampled right eye. Without and washing her hands after in the right eye, she in bottle and resident's to administer a drop to the		4)	How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Nursing will present The findings of weekly "Medication Adr. Audit to the Performance Improvement Comonthly for one year. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Purineer Office Management Committee Committ	Committee ee	,23
	Admini "Should hands In an ir 3/2/12 LPN #2 washed through have cl	stration for Eye of both eyes requested the strategy of the st	policy for Medication Instillation, revealed: ire instillation, wash your ne second eye." Director of Nursing on 10:00 a.m., she stated moved her gloves and administering medication by tube and LPN #1 should etween administering eye			Medical Director, Business Office Manage Development Coordinator, Wound Care Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Servi Director of Human Resources, Director of Services, Director of Activities, Director Director of Food and Nutrition Services, Director of Admissions/Marketing will rethe findings and make recommendations develop plans of action if any areas are not be non-compliant.	Nurse, ctor ces, of Rehab of Nursing and eview and	3/23/12
		d)(1)(iv)-(v) BEI . PRIVACY	DROOMS ASSURE FULL	F 46	60			

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SIATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-039 SURVEY PLETED	
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1		OR SUPPLIER ER OF RHEA CO	UNTY		78;	EET ADDRESS, CITY, STATE, ZIP CODE 24 RHEA COUNTY HWY AYTON, TN 37321	-	3/02/2012
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	Bedro assure In facil except ceiling the becombir This Riby: Based Directo facility rooms four (24 long enduced the Directo the Directo facility rooms (2) to the Directo full visua The Directonfirme enough. During an enough of the privation of the Directo forms (2) to the privation of the Directon of	ities initially cert in private rooms suspended curt d to provide total ation with adjace EQUIREMENT on observation of Maintenance failed to ensure to Rooms 8A, 29A) sampled reside ough to ensure for lings include: the observational ed on 2/29/2012 ctors of Maintenance cy curtain in roo the (3) feet too in it privacy when finctor of Maintenance d that the curtain observation of	signed or equipped to cy for each resident. Ified after March 31, 1992, s. each bed must have ains, which extend around visual privacy in ent walls and curtains. Is not met as evidenced and interview with the e and Housekeeping, the hat three (3) resident and 30A) out of twenty ents had privacy curtains ull visual privacy. I tour of the facility at 11:50a.m. along with ance and Housekeeping, ms 8A and 29A were two arrow in width to provide	F 4) W to	What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? The Director of Environmental Service Replaced the privacy curtain in resident Rooms 8A, 29A, and 30A on 3/2/12. The privacy curtains are long enough To ensure full visual privacy. How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Environmental Services Audited residents rooms on 3/2/12 for Proper width of privacy curtains, and 37 were replaced. These were rooms 1-10, and 20-49. What measures will be put into place or that systematic changes will you make ensure that the deficient practice will not be director Environmental Services ill audit privacy curtains for proper dth to ensure visual privacy weekly rethree months, and replace as necessary	ot recur?	3/23/12
i t	Nursing A the privace prevent the the door to	Assistants (CNA) by curtain toward he resident from to the room was	#3 and #4 had to pull I the head of the bed to being exposed when opened and had to pull t of the bed when the					

			ND HUMAN SERVICES MEDICAID SERVIÇES				FOI	ED: 03/14/2012 RM APPROVED NO: 0938-0331
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F 460	reside The cu privacy In an ii observ	rtain was too not for the resident of the resi	ppened the bathroom door. arrow to provide full visual	F 4	4)	How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Environmental Service The findings of weekly "Privacy Curtai Audit to the Performance Improvement Commit monthly for one year. The Performance Improvement Commit consisting of the Executive Director, Medical Director, Business Office Man Development Coordinator, Wound Car Director of Medical Records, Director of Social Services of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director Services, Director of Activities, Director Director of Food and Nutrition Services Director of Admissions/Marketing will the findings and make recommendations levelop plans of action if any areas are as an enon-compliant.	n" Committee ttee ager, Staff e Nurse, ector vices, of Rehab r of Nursing , and review s and	

PRINTED: 03/14/2012